Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 15, 2019	2019_674610_0020	000233-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of London
355 Wellington St, 2nd Floor, Suit 248 LONDON ON N6A 3N7

Long-Term Care Home/Foyer de soins de longue durée

Dearness Home for Senior Citizens
710 Southdale Road East LONDON ON N6E 1R8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 3, 2019

This inspection was completed related to:
Critical Incident Report #M51400000119, Log #000233-19, allegations of staff to resident verbal abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Security Guard(s), and Physiotherapist and resident(s).

Inspectors also reviewed relevant record documentation, completed interviews and observed staff to resident care and interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

The licensee failed to ensure that no person performs their responsibilities before receiving training in the areas mentioned on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

S. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

The Ministry of Health and Long term Care (MOHLTC) received a Critical Incident Report (CIS), from the home regarding allegations of staff to resident abuse.

Section 2 (1) of the Ontario Regulation 79/10 defined Verbal Abuse any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where

the resident making the communication understands and appreciates its consequences.

The ADOC told the inspector that outside agency had been hired to provide care services to ensure that the resident's responsive behaviours were not escalating and were to be monitored. The ADOC also said that the outside agency had been providing ongoing care services for approximately five months

The home's policy "Resident Abuse-by Persons other than Staff" ADMI-02-02-04 a stated in part that the Administrator/Designate was responsible for ensuring that the "Resident Abuse by Persons other than Staff" policy and procedures were communicated to all persons having any type of working or non-working relationships with the home.

The outside agency record documentation did not show that there was documented evidence that the outside agency had received training and education on the "Resident Abuse by Persons other than Staff" policy and procedures prior to performing their responsibilities.

In an interview the outside agency said that they were provided a policy to read regarding zero tolerance of abuse and had signed that they had reviewed/read the policy.

The "Signature Page" provided by the outside agency was not titled as to what policy was read. However the signature page showed that four outside agency had read the policy recently.

The ADOC acknowledge that the outside agency had not been provided the policy to read regarding "Resident Abuse by Persons other than Staff" policy and procedures prior to performing their responsibilities and should have.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 215. Police record check

Specifically failed to comply with the following:

s. 215. (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 451/18, s. 3 (1).

Findings/Faits saillants :

The licensee had failed to ensure that police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 451/18, s. 3 (1).

s.75. (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. 2007, c. 8, s. 75. (1).

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

The Ministry of Health and Long term Care (MOHLTC) received a Critical Incident Report (CIS) from the home regarding staff to resident verbal abuse.

Section 2 (1) of the Ontario Regulation 79/10 defined Verbal Abuse as: any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Section 2 (1) of the Ontario Regulation 79/10 defined staff as: Interpretation of "staff", in relation to a long-term care home, means persons who work at the home; (a) as employees of the licensee, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

The ADOC told inspector that the outside agency hired was to provide care services to ensure that the resident did not expressive responsive behaviours with physical aggression. The ADOC also said that the outside agency has been providing ongoing care services.

Documentation review of the outside agency records provided showed that there was no evidence that screening measures included police record checks were completed and that the police record check was a vulnerable sector check. Further review of three outside agency records also showed that there was no evidence of a police record check and that the police check included a vulnerable sector check.

During a telephone interview with the Assistant Director of Care (ADOC) and the Director of Care, they both stated that they believed the manager of security at the city was responsible for ensuring police checks were completed for the home.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a police record check has a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect, to be implemented voluntarily.

Issued on this 23rd day of May, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.